SENATE FISCAL AGENCY
MEMORANDUM

DATE: December 8, 2003

TO: Members of the Michigan Senate

FROM: Steve Angelotti, Fiscal Analyst
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RE: Medicare Prescription Drug Act

On Tuesday, November 25, 2003, the United States Senate adopted the conference report on HR 1, the Medicare Prescription Drug Reform Act. This followed approval the previous week by the United States House of Representatives. The bill was signed into law today by President Bush.

The most significant provision of the Act is the creation of a Medicare prescription drug benefit. In the past, Medicare did not cover the cost of medications prescribed outside of a hospital setting. The full benefit will take effect on January 1, 2006, with a discount card being made available to Medicare recipients six months after enactment (June 2004), to ensure that discounts are available for Medicare recipients who do not have other pharmaceutical coverage.

The Act includes numerous provisions affecting other aspects of the Medicare program, provisions affecting the Medicaid program, and provisions relating to other senior-oriented health issues.

The purpose of this memorandum is to examine the effects of the Act on the State of Michigan and State programs, particularly Medicaid and the Elder Prescription Insurance Coverage (EPIC) program.

EFFECTS OF THE MEDICARE PRESCRIPTION DRUG REFORM ACT ON MICHIGAN MEDICAID PHARMACEUTICAL EXPENDITURES AND THE ELDER PRESCRIPTION INSURANCE COVERAGE (EPIC) PROGRAM

The changes to Medicare included in the Act will provide coverage for pharmaceuticals, beginning January 1, 2006, to all Medicare recipients who elect to have such coverage.

The Act also will direct the Medicare system to pick up a portion of the pharmaceutical costs for "dual eligibles" (Medicare-eligible individuals who are also enrolled in the Medicaid program). As noted above, before enactment of this Act, Medicare recipients were not covered for pharmaceuticals. Dual eligibles, those enrolled in both Medicare and Medicaid, do have their prescriptions covered through the State's Medicaid program.

Dual eligibles will not be covered under the Medicare benefit; they will continue to have their prescription costs paid by their respective state's Medicaid program. As part of a compromise made to address concerns of the states, the Medicare program will pick up a portion of the estimated cost of each state's Medicaid dual eligible prescription expenses.

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EFFECTS ON MEDICAID PHARMACEUTICAL EXPENDITURES FOR MEDICARE/MEDICAID DUAL ELIGIBLES

The impact on State expenditures for dual eligibles is relatively clear-cut, at least when compared with other aspects of the program. Starting in 2006, Medicare will pay 10% of the estimated Medicaid pharmaceutical costs for the estimated 180,000 Michigan residents who are projected to be dual eligibles in 2006. That reimbursement percentage will increase by 1-2/3% each year until 2015 (a provision that has been nicknamed the "claw-back" provision), when Medicare will pay 25% of the Medicaid pharmaceutical costs for dual eligibles.

The adjusted cost used by the Federal government for this estimate will be the fiscal year (FY) 2002-03 estimated General Fund/General Purpose (GF/GP) cost for pharmaceuticals for dual eligibles, adjusted upward by 11%-12% per year to reflect projected increased expenditures. In years after 2006, the estimated cost will be adjusted by growth in Medicare prescription drug expenditures.

The best estimate of State spending on pharmaceuticals for dual eligibles in FY 2002-03 is about $180,000,000 GF/GP. If that amount is correct and is inflated by the assigned amounts of 12.4% for FY 2003-04, 11.7% for FY 2004-05, and 11.1% in FY 2005-06, the base amount will be about $250,000,000 GF/GP. The Medicare program then will pick up 10% of that cost in calendar year 2006, so Michigan will see about a $19,000,000 GF/GP saving in the last three quarters of FY 2005-06. That amount is projected to increase to a full-year amount of $25,000,000 in FY 2006-07.

The portion of estimated dual eligible pharmaceutical costs paid by Medicare will gradually increase over the next nine years to 25% of estimated costs in FY 2014-15, or a base amount of $60,000,000 GF/GP, which will then be inflated by the increase in Medicare prescription drug costs over that period. If costs increased 8% per year from 2006 through 2015, then the Medicare program would pick up about $120,000,000 of the 2015 GF/GP Medicaid pharmaceutical costs for dual eligibles. Over the 10-year period from 2006 to 2015, the State would see total estimated savings of about $650,000,000 GF/GP. Even if the average annual Medicare prescription cost increases were significantly lower, say 5%, the State still would see considerable 10-year savings of about $550,000,000 GF/GP.

EFFECTS ON THE EPIC PROGRAM

The Act creates a Medicare prescription drug coverage program effective January 1, 2006. Before 2006, there will be a limited prescription drug benefit that will have a major impact on EPIC. The following discussion looks at the 2004-2005 effects as well as the long-term effects on EPIC.

<u>Changes for 2004 and 2005</u>

All Medicare beneficiaries will receive Medicare-endorsed pharmaceutical discount cards beginning six months after enactment (June 2004) until the implementation of the Medicare drug benefit on January 1, 2006. One of the advantages of the card will be bulk purchasing discounts available to those who use the card. This is not likely to have a major impact on the EPIC program (or for Medicare/Medicaid dual eligibles) as the State already aggressively pursues discounts and rebates.

The other major change due to the discount card will be coverage of up to $600 per year for those under 135% of the Federal poverty level. Eligible beneficiaries will pay 5% coinsurance if they are under 100% of the Federal poverty level; 10% if they are between 100% and 135% of poverty.

Currently, EPIC covers about 15,000 people, of whom about 10,000 are under 135% of poverty. Various attempts at cost and cost distribution modeling based on EPIC data provided by the Department of Community Health indicate that most EPIC users but not all spend at least $600 per year, with an estimated average saving to the State of $560 per person per year. This means that having the first $600 covered would save the State about $5,600,000 million in EPIC costs if the discount card savings may be applied retroactively to all FY 2003-04 costs. (If not, the savings would be about $1,500,000 in FY 2003-04 before growing to $5,600,000 million in FY 2004-05.) If those savings were used to expand the program, an additional 4,000 individuals could be covered full-year at an average cost of $1,400 per person ($1,400 being the expected average cost after taking into account the fact that most of these individuals would qualify for the $600 per person coverage).

This ability to expand the covered population by 4,000 people pales in comparison to the ability to expand if the State's currently pending Medicaid Pharmacy Plus waiver is approved. That waiver would allow Medicaid match dollars to be used to cover individuals and would stretch the current $30,000,000 in Tobacco Settlement revenue to over $68,000,000, effectively allowing for a doubling of the covered population.

Changes in 2006 and Beyond

The implementation of a Medicare pharmaceutical benefit on January 1, 2006, will have a major impact on EPIC. This program was designed to be a "Medigap" insurance coverage for seniors under 200% of poverty. Due to budgetary constraints, EPIC does not cover all seniors under 200% of poverty, but rather is focused on those individuals formerly served by the Michigan Emergency Pharmaceutical program and the Senior Prescription Drug Tax Credit.

Language in the EPIC statute allows the program to be altered to reflect any Federal Medicare drug benefit, by picking up costs not covered by the drug benefit (Section 9 of the EPIC statute states, "If the federal government establishes a pharmaceutical assistance program that covers EPIC eligible seniors under medicare or another program, the EPIC program shall cover only eligible costs not covered by the federal program").

There are five separate groups that will be affected by both the Federal Medicare benefit and any changes to EPIC:

1. People under 135% of poverty with less than $6,000 in assets (single) or $9,000 in assets (couple)

These individuals will face only co-pay costs ($2 on generics, $5 on brand names) and no other costs. The EPIC program will no longer need to cover these individuals. Various income and asset data collected over time indicate that about two-thirds of the EPIC-eligible individuals who are under 135% of poverty will meet the asset requirements. This means that of the 10,000 or so EPIC recipients under 135% of poverty, the State will no longer need to pay pharmaceutical costs for two thirds of them.

2. People between 135% and 150% of poverty with less than $10,000 in assets (single) or $20,000 in assets (couple)

These individuals will face co-pays and a $50 deductible, and will be required to cover 15% of costs up to the roughly $5,000 catastrophic coverage limit. Thus, their costs may be up to $750 per year plus co-pays. Various income and asset data indicate that about half of the EPIC-eligible individuals between 135% and 150% of poverty will meet the asset requirements. This means that of the 5,000 or so EPIC recipients between 135% and 150% of poverty, half will have pharmaceutical costs capped at $750 per year. The Senate Fiscal Agency's (SFA's) modeling indicates that the average out-of-pocket pharmaceutical cost for these individuals under the Medicare benefit will be $250 per year. The EPIC program could be redesigned to cover part or all of that cost. Covering an average of $250 for 2,500 individuals would cost $625,000 per year, far less than the current estimated $4,000,000 per year spent by EPIC on those between 135% and 150% of poverty who meet the asset requirements.

3. People under 135% of poverty who do not meet the asset requirements

These individuals, about one third of the population under 135% of poverty, will have the regular Medicare drug benefit, not the enhanced benefit.

4. People between 135% and 150% of poverty who do not meet the asset requirements

These individuals, about one half of the population between 135% and 150% of poverty, will have the regular Medicare drug benefit, not the enhanced one.

5. People between 150% and 200% of poverty

These individuals will have the regular Medicare drug benefit.

Cost Structure for Those with the Regular Medicare Drug Benefit

The Medicare drug benefit includes a $250 deductible, an estimated $35 per month ($420 per year) premium, $2 co-pays for generics and $5 co-pays for brand names, and full coverage up to $2,200 per year. After that point, the so-called "donut" takes effect, and costs are not covered until the covered person has spent a total of $3,600 on the deductible, on premiums, and on co-pays. After that point, achieved at roughly $5,000 in drug costs, catastrophic coverage (with 5% cost-sharing) kicks in.

The EPIC program, which covers all costs beyond a $25 application fee and a sliding scale 1%-5% co-pay, could be restructured to cover some of the costs not picked up by the Medicare drug benefit. The structure would have to be determined and could be directed by the Legislature through changes to the EPIC statute or through boilerplate.

For instance, the EPIC program could cover costs between $2,200 and $5,000 per year (the so-called "donut"), but not the deductible, premiums, or co-pays. Based on the data reported to the Department and modeling done by the SFA, that approach would have an average cost of $500 per eligible individual. Presumably, many would not elect to have EPIC coverage as

three-fourths of the individuals who could be covered would not exceed $2,200 in pharmaceutical costs. One can confidently state, however, that the $38 million available if the Pharmacy Plus waiver goes through could guarantee no "donut" problems for 76,000 potential eligible individuals ("eligibles").

Another approach would be for the EPIC program to cover the premiums and costs between $2,200 and $5,000 per year, while keeping the $250 deductible and the co-pays as the client's responsibility. That would lead to an average cost of about $920 per year ($500 plus the $420 annual premium). Under this system, eligible people likely would accept EPIC coverage because they would have their premium costs covered, so about 40,000 potential eligibles would seek coverage and would be able to avoid both premiums and "donut" problems.

The next question is, how many people under 200% of poverty are not covered by private insurance, are not on Medicaid, and are not enrolled in EPIC? In other words, what is the potential universe of EPIC clients if the program is revamped and the covered population expanded?

Based on income data reported to the Federal government, the SFA estimates that there are about 300,000 seniors in Michigan who are under 200% of poverty and are not on Medicaid, of whom 130,000 likely have pharmaceutical coverage either through private insurance from their former employer or due to meeting the asset/income requirements for nearly complete Medicare pharmaceutical coverage. This leaves 170,000 potential clients.

Of these, about 5,800 would be EPIC participants under 150% of poverty who, due to not meeting the asset requirements, would not receive nearly complete Medicare pharmaceutical coverage. Restoring coverage akin to EPIC (with costs similar to the application fee and co-pays) would cost about $800 per client, or about $4,600,000 per year.

The remaining 164,200 potential clients under 200% of poverty could be covered under a Medigap approach. As noted above, full coverage of the "donut" would cost on average $500 per person per year, or about $82,100,000 in total. Coverage of the "donut" and the monthly premiums would cost about $920 per person per year or about $151,000,000 in total.

It appears that approximately 75,000 potential clients under 150% of poverty would seek coverage under a Medigap approach. Full coverage of the "donut" at the above-noted average of $500 per person per year would cost about $37,500,000. Coverage of the "donut" and the monthly premiums at $920 per year would cost about $69,000,000.

If the Pharmacy Plus waiver is approved, the EPIC program, without any other funding changes, will have about $63,500,000 to spend after those between 135% and 150% of poverty regain coverage similar to EPIC . This $63,500,000 would allow coverage for three quarters of the individuals under 200% of poverty if the "donut" is covered but not the deductible or premiums (or up to about 180% of poverty). If the monthly premiums were covered as well, a combined EPIC/Medicare coverage could be provided to all those under 150% of poverty at only a minimal increase in cost.

If the Pharmacy Plus waiver is not approved, the EPIC program, absent any other funding

changes, will have $30,000,000 available, or about $25,400,000 to spend after those between 135% and 150% of poverty regain coverage similar to that what enjoyed under EPIC. This $25,400,000 would allow coverage for about 30% of those under 200% of poverty if the "donut" were covered but not the deductibles or premiums (or up to about 140% of poverty).

It should be noted that these are very rough estimates, based on population, income, and expenditure data from multiple sources. It should further be noted that these estimates are based on mathematical modeling using actual EPIC data. Thus each of the estimates on eligible populations, costs per client, and overall costs is best described as a midpoint best-guess estimate. Before any revisions to EPIC take place, one assumes that an effort would be undertaken to estimate costs in a more rigorous fashion.

MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PROVISION

The Act includes a provision increasing each state's DSH limit by 16%, with an additional provision allowing continued increases in the DSH limit for low DSH states (a provision that will not apply to Michigan).

At the present time, Michigan is in danger of exceeding its DSH ceiling unless Adult Benefits Waiver (ABW) part I is approved by the Center for Medicare and Medicaid Services (CMS). Verbal approval was granted, but final written approval has not been given, so the waiver is still on hold. The danger is that the State will be liable for about $50,000,000 GF/GP due to exceeding the DSH ceiling if the waiver is not granted. The 16% provision will eliminate most of this potential problem. If ABW I is approved, the higher DSH ceiling will allow for increased Medicaid special financing, with potential savings of $40,000,000 GF/GP, which would help offset the rather large Medicaid shortfall in the FY 2003-04 budget.

DEMONSTRATION PROJECTS ON BACKGROUND CHECKS FOR LONG TERM CARE EMPLOYEES

The Act includes language establishing a two-year $25,000,000 demonstration project for 10 states to fund background checks for long-term care facility employees. Michigan already does background checks, through the State Police and the Department of Consumer and Industry Services. It is not clear whether Michigan will be able to avail itself of these funds as only 10 states will be eligible, but it is a provision that could work to the State's advantage both in terms of finances and in terms of protecting those in long-term care facilities.

EMERGENCY HEALTH SERVICES FOR UNDOCUMENTED IMMIGRANTS

The Act appropriates $167,000,000 per year to the 50 states in proportion to each state's share of undocumented immigrants residing in that state. It is not clear how much money Michigan will stand to gain from this provision, although some general surveys indicate that approximately 1% of the nation's undocumented immigrants reside in Michigan. This would translate to $1,670,000 per year in Federal funding that could be distributed to providers to cover uncompensated care for emergency health services to undocumented immigrants.

SUBSIDY TO COVER STATE RETIREES' PRESCRIPTION COSTS

Many employers cover the prescription costs of retirees. One of the concerns about the Medicare proposal is that it will lead to employers' dropping coverage for their retired employees. In order to avert this possibility, the Act includes a subsidy that will cover 28% of allowable Medicare-eligible retiree costs above the $250 deductible up to $5,000.

By 2006, the State should have about 30,000 retirees who are Medicare-eligible. Typical pharmaceutical expenditures for seniors are in the range of $1,500 per year, so a 28% subsidy of costs above the $250 deductible (capped at $5,000) will save the State an average of $300 per retiree. Total savings to the State's retirement system are projected to be approximately $9,000,000 per year.

OVERALL IMPACT

The implementation of the Medicare Prescription Drug Reform Act will have a positive impact on the State of Michigan's finances. None of the major provisions will increase State costs above what they would have been absent passage of the Act; instead, the provisions will all reduce costs. The final implementation of the benefit in January 2006 will give the State an opportunity to expand the EPIC program greatly without any additional cost. The State will see major savings from the so-called "claw-back" provision for Medicare/Medicaid dual eligibles. The increase in the DSH ceiling will, at minimum, prevent a major cost increase in case the Federal government does not approve the Adult Benefits Waiver part I. Finally, the State will see savings to its retirement system.

Impact of the Medicare Prescription Drug Reform Act - Summary Table

State Expenditures for Medicaid Dual Eligibles	The State will see nine-month savings of $19,000,000 GF/GP in 2006 ($25,000,000 GF/GP full-year), increasing to about $100,000,000 to $120,000,000 GF/GP by FY 2014-15, when Medicare will pick up 25% of Michigan's dual eligible pharmaceutical costs.
Elder Prescription Insurance Coverage (EPIC) Program	• In 2004 and 2005, the State will save $5,600,000 annually due to the $600 per year savings from the discount card for those under 135% of poverty. If payments for expenditures before implementation in June 2004 are not covered, then FY 2003-04 savings will be about 1,500,000. • In 2006 and beyond, the elimination of almost all pharmaceutical costs for those seniors under 150% of poverty who meet asset requirements will save the State $16,000,000 per year, assuming no EPIC expansion. • Expansion of EPIC to serve as Medigap coverage would cost an average of $500 per person per year if the costs between $2,200 and $5,000 were covered, and $920 per person per year if the $35 per month premium also were covered.

Disproportionate Share Hospital (DSH) Payments	Increasing the State's DSH limit by 16% will save about $40,000,000 GF/GP per year *if* the additional DSH financing is used for increased Medicaid special financing. If Adult Benefits Waiver (ABW) I is not approved, the State will be $50,000,000 GF/GP over its DSH limit and the additional $40,000,000 will reduce, but not eliminate, the problem.
State Retirees' Prescription Costs	The 28% subsidy of costs between $250 and $5,000 will save, on average, about $300 per year per retiree. Assuming 30,000 Medicare-eligible retirees in 2006, this means annual savings of $9,000,000 per year.
Overall Impact	• Total potential savings in FY 2003-04, assuming no expansion of EPIC, will be between $41,500,000 and $45,600,000 GF/GP or GF/GP equivalent if the additional DSH money is used for special financing and if ABW part I is approved. Without approval of ABW Part I, the FY 2003-04 savings will be nominal. • Total potential savings in FY 2005-06 will be $84,000,000 GF/GP or GF/GP equivalent if the additional DSH money is used for special financing and if EPIC is not expanded.

While precise estimates will be difficult to make before better data are obtained, a round estimate of annual savings in 2006 and beyond, assuming no policy changes, of over $80,000,000 GF/GP per year is quite reasonable, and it is reasonable to predict that savings will increase over time. This estimate, however, is based on the assumption that no policies are changed and that the EPIC program will not be expanded. If the EPIC program is expanded, then the net savings will be reduced.

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